Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Mumps

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name _____
Phone _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Swollen salivary glands (parotitis)**
☐	☐	☐	☐	Fever Highest measured temp: _____ °F
				Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Seizures new with disease
☐	☐	☐	☐	Hearing loss resulting from current illness

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Parotitis**
☐	☐	☐	☐	Encephalitis or encephalomyelitis
☐	☐	☐	☐	Meningitis
☐	☐	☐	☐	Acute pancreatitis
☐	☐	☐	☐	Orchitis
☐	☐	☐	☐	Mastitis
☐	☐	☐	☐	Complications

Specify: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Vaccine up to date for mumps

Number MMR doses after first birthday: _____
Vaccine series not up to date reason:
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous infection confirmed by laboratory
☐ Previous infection confirmed by physician
☐ Parental refusal ☐ Under age for vaccination
☐ Other: _____
☐ Unk

☐ ☐ ☐ ☐ Primary vaccine series complete

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

P	N	I	O	NT	
☐	☐	☐	☐	☐	**Mumps virus culture (clinical specimen)**
☐	☐	☐	☐	☐	**Mumps IgG with significant rise (acute and convalescent serum pair)**
☐	☐	☐	☐	☐	**Mumps IgM**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

Enter onset date (first symptom) in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		***Contagious period***	
Days from onset:	-18	-15	1 week prior	onset to 9 days after onset
Calendar dates:				

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____
_____

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ ☐ ☐ ☐ Contact with confirmed or probable case

☐ ☐ ☐ ☐ Contact with recent foreign arrival
Specify country: _____

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

Y N DK NA

☐ ☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Exposure setting identified:
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel
☐ Other, specify: _____ ☐ Unknown

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed or probable case**

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool

☐ ☐ ☐ ☐ Employed in child care or preschool

☐ ☐ ☐ ☐ Do any household members work at or attend child care or preschool

☐ ☐ ☐ ☐ Documented transmission
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Exclude exposed susceptibles from work/school for incubation period

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

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